



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: NORTHWEST TEXAS HOSPITAL 3255 WEST PIONEER PARKWAY ARLINGTON TX 76013	MFDR Tracking #: M4-11-3608-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICAN HOME ASSURANCE COMPANY Rep Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Northwest Texas Hospital to audit their Workers Compensation claims. We have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008 for the following HCPC's: **HCPC...76000...97597.**" **"Please submit this claim for the correct allowable per ASC RULE 134:402: Outpatient Hospital Rule 134.03, HCPC's are payable at 200% of the correct fee schedule allowable."**

Amount in Dispute: \$199.41

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier, American Home Assurance reviewed the additional information submitted by the requester, Northwest Texas Hospital for the 1/7/2011 through 1/11/2011 date of service. The carrier is maintaining their position that Northwest Texas Hospital is not entitled to additional money (\$199.41). The Carrier had the bills processed two times and the bill was paid accordingly. The bill will be resubmitted one additional time with the information provided by Carol Ford to see if any additional money is owed."

Response Submitted by: Flahive, Ogden & Latson, Attorney At Law, PC, 504 Lavaca, Suite 1000, Austin, Texas 78701

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
01/07/2011 Through 01/11/2011	Hospital Outpatient Surgical Services	Total APC: \$188.14 Total MAR: \$188.14 Respondent Paid: \$141.05 Requestor Due: \$47.09	\$199.41	\$47.09
Total Due:				\$47.09

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:

Explanation of benefits dated 02/17/2011 noted claim reduction codes:

- Z652 — Recommendation of payment has been based on this procedure code, 97597, which best describes services rendered.
- Z560 — The charge for this procedure exceeds the fee schedule or usual and customary allowance.
- Z652 — Recommendation of payment has been based on this procedure code, 76000, which best describes

services rendered.

Explanation of benefits dated 04/25/2011 noted claim reduction codes:

- Z652 — Recommendation of payment has been based on this procedure code, 97597, which best describes services rendered.
- Z560 — The charge for this procedure exceeds the fee schedule or usual and customary allowance.
- Z652 — Recommendation of payment has been based on this procedure code, 76000, which best describes services rendered.
- X395 — This bill was paid according to fee schedule/usual and customary guidelines. No additional payment is recommended.

2. Division rule at 28 TAC §134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:
 - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
 - (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables."
3. Pursuant to Division rule at 28 TAC §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
 - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 200 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent."
4. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:
 - (1) No documentation was found to support a contractual agreement between the parties to this dispute;
 - (2) MAR can be established for these services; and
 - (3) The submitted documentation does not support that the provider requested separate reimbursement for implantables with the billing.
5. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.
6. Reimbursement is calculated as follows:

The total Medicare facility specific amount is \$94.07
This amount multiplied by 200% = \$188.14
Total Maximum Allowable Reimbursement (MAR) is \$188.14
This amount less the amount previously paid by the respondent of \$141.05
leaves an amount due to the requestor of \$47.09.
This amount is recommended.

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code §413.031(c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is \$47.09.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031, §413.0311
28 TAC §133.305, §133.307, §134.403

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$47.09 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature

Medical Fee Dispute Resolution Officer

08/30/2011

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.